Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DAVID TEUSCHER MD
3650 LAUREL AVENUE
BEAUMONT TX 77707

[redacted]

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box 45

MFDR Date Received
NOVEMBER 5, 2012

MFDR Tracking Number
M4-13-0641-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The following is an appeal for non-payment of outpatient consultative services, (CPT codes 99241-99245), for Texas Workers Compensation cases covered under the Division of Workers Compensation and the Workers Compensation Act. The carrier has unilaterally determined that because Medicare has chosen in 2010 to cease reimbursing for these codes…for reasons that have nothing to do with the Texas Workers Compensation healthcare delivery system that they can unilaterally refuse to recognize and reimburse those evaluations and management (E&M) codes, for which services have been provided as requested and appropriately billed…the E&M services provided in consultation, whether outpatient or inpatient, at the request of another healthcare provider are in fact a higher level of evaluation and management due to the complexity of the patient's presentation and condition and thus the current procedural terminology (CPT codes assigned greater relative value to those codes for that specific purpose)…"

Amount in Dispute: $235.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Commission adopted the Center for Medicare and Medicaid payment policies relating to coding, billing, and reporting as well as payment policies that affect utilization of services, applicable to all dates of service on or after 08/01/03. In review of the disputed services, the Office maintains the denial for CPT code 99243 for ANSI code 96 – Non-Covered Charge(s) and 125 – Payment adjusted due to submission/billing error(s). Effective January 1, 2010, the consultation codes are no longer recognized for Medicare Part B payment. Physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. The requestor has failed to submit a claim correcting the CPT code to reflect the E/M codes that represent the visit performed."

Response Submitted by: State Office of Risk Management, P. O. Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 2, 2012	99243 Consultation Service	$235.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for medical bill submission by a health care provider.
3. 28 Texas Administrative Code §134.203 sets out the medical fee guideline for professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits
   - 96 – NON-COVERED CHARGE(S).
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 125 – PAYMENT ADJUSTED DUE TO A SUBMISSION/BILLING ERROR(S). ADDITIONAL INFORMATION IS SUPPLIED USING THE REMITTANCE ADVICE REMARK CODES WHENEVER APPROPRIATE.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 99243 CPT code billed has a status of 1 – Indicates that this code is not valid for Medicare purposes. Medicare does not recognize codes assigned this status. Medicare uses another code for reporting of, and payment for these services. *Resubmit complete bill to carrier within original timely filing deadline for further review.

Issues

1. Did the requestor correctly code the service in dispute?
2. What is the applicable fee guideline for the service in dispute?
3. Is the requestor entitled to reimbursement under §134.203(d)(e) or (f)?

Findings

1. 28 Texas Administrative Code §133.20(c) states "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills." According to the documentation submitted, the service in dispute is a professional service described as an office consultation for a new or established patient. This service may be found in the evaluation and management section of the American Medical Association (AMA), Current Procedural Terminology (CPT) code set. This service was billed by the requestor under CPT code 99243. The applicable division fee guideline is 28 Texas Administrative Code §134.203 Titled *Medical Fee Guideline for Professional Services*. The carrier denied payment alleging that code 99243 is not valid for Medicare purposes. 28 Texas Administrative Code §134.203 (b) (1) states, in pertinent part, that "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing;…in effect on the date a service is provided with any additions or exceptions in the rules." Section 134.203(a)(5) defines "Medicare payment policy" to mean reimbursement methodologies, models, and values weights including its coding, billing and reporting payment policies as set forth in the Centers for Medicare and Medicaid services (CMS) payment policies **specific to Medicare**.

   The Medicare policy applicable to the disputed service can be found at www.cms.gov in the *CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 1875, Change Request (CR) 6740*, dated December 14, 2009, effective January 1, 2010. CR#6740 states that the use of all consultation codes (ranges 99241-99245 and 99251-99255) was eliminated effective January 1, 2010. This code range includes the code 99243 which the requestor reported on its medical bills. Medicare policy directs physicians and qualified non-physician practitioners to discontinue use of consultation codes, and instead use the CPT codes 99201-99215 as appropriate for the level of service provided. Corresponding *Medicare Learning Network (MLN) Matters* article number MM6740 was published to further explain this requirement. A subsequent Change Request CR#7405, and its corresponding MLN Matters article MM7405 was published on January of 2011 to reiterate the policy regarding consultation codes. In CR#7405, physicians were reminded that "As explained in CR 6740, Transmittal 1875, Revisions to Consultation Services Payment Policy, issued on December 14, 2009, physicians **shall** [emphasis added] code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. CMS instructed

providers billing under the PFS to use other applicable E/M codes to report the services that could be described by CPT consultation codes."

28 Texas Administrative Code §134.203 (a)(8) specifies: "Whenever a component of the Medicare program is revised, use of the revised component shall be required for compliance with Division rules, and orders for professional services rendered on or after the effective date, or after the effective date of the revised component, whichever is later." The division concludes that the requestor failed to code the services in dispute in accordance with the applicable Medicare policy in effect on the date the service in dispute was provided, thereby failing to meet the correct coding requirements of §133.20(c), and §133.203 (b)(1).

2. The fee guideline applicable to the service in dispute is 28 Texas Administrative Code §134.203, Titled *Medical Fee Guideline for Professional Services*. In the absence of a contracted rate, the reimbursement for a professional service, including an evaluation and management service, is established under paragraph (c). §134.203 (c) states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32." As discussed above, the term "Medicare payment policy" is defined for this rule by §134.203 (a)(5). The definition includes billing the correct codes as specified by Medicare. In paragraph 1, the division concluded that the requestor did not specify the correct billing codes. For that reason, no reimbursement can be recommended under §134.203(c)(1).

3. In its position, the requestor suggests that there may be a method of payment for the service in dispute that is not based in Medicare, and objects to the carrier's refusal to pay for an evaluation and management service. The requestor states "It should be noted that the Federal Centers for Medicare and Medicaid Services is not solely Medicare, but also has policy for Medicaid, Tricare, and Medicare Advantage Plans and payments all of which continue to honor and reimburse the consultation codes...Lastly, House Bill 7, Section 3.233, amended Texas Labor Code Section 413.011. (b) to state specifically that 'the commissioner shall also provide for reasonable fees for the evaluation and management of care as required by Section **[**408.025**]**.(c), and commissioner rules'." The division describes those products and services payable using other payment factors and requirements in paragraphs (d), (e) and (f). Each of these paragraphs describes the types of services, billing codes, and the method of calculation for the specified services.
    - §134.203(d) and (e) do not include provisions for payment of evaluation and management codes. No payment can be recommended because the service in dispute is not included under the items payable in these paragraphs.
    - §134.203 (f) states that "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)." No payment can be recommended under §133.203(f) because Medicare assigns a payment to the evaluation and management service provided if properly coded.

    The division concludes that §134.203(d), (e) and (f) do not apply to the service in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled $0.00 reimbursement for the service involved in this dispute.

Authorized Signature

[redacted]	[redacted]	April 11, 2013
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812